UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 10, SUBREGION 11

MISSION HOSPITAL,

Employer

and **Case 10–RC–257615**

NATIONAL NURSES ORGANIZING COMMITTEE/NATIONAL NURSES UNITED, AFL-CIO,

Petitioner

REGIONAL DIRECTOR'S DECISION AND ORDER

I. INTRODUCTION

Petitioner National Nurses Organizing Committee/National Nurses United, AFL-CIO, seeks to represent a unit comprising "all full-time, regular part-time, and per diem Registered Nurses employed by [Mission Hospital] at its facility located at 509 Biltmore Ave., Asheville, NC 28801 and 428 Biltmore Ave., Asheville, NC 28801." The Employer, Mission Hospital, contends the petitioned-for unit is inappropriate, and the smallest appropriate unit must include registered nurses working for two other employers that purportedly compose a single employer with Mission Hospital, including nurses working at other locations of the purported single employer, and other Registered Nurses, including Certified Registered Nurse Anesthetists, physicians assistants, and nurse practitioners working its various facilities throughout Buncombe County, North Carolina. Hearing Officer Ingrid Jenkins conducted a telephonic hearing[1] in this matter over 12 days during

[1] On April 3, 2020, the Acting Regional Director ordered a telephonic hearing in this matter noting that, at the time, the National Labor Relations Board had physically closed its offices, including its Subregional office in Winston-Salem, North Carolina, and ordered its employees to telework from home indefinitely because of the global Coronavirus pandemic. The Acting Regional Director also noted that state and local governments within Region 10's geographical limits had at that time issued orders or urged its citizens to shelter at home and to avoid public gatherings. Pursuant to the Board's mandatory telework order, the hearing officer conducted this hearing by telephone. After the hearing concluded, the Board

the period April 14 to May 6, 2020.[2]

As set forth more fully below, I find the Employer's facilities at 509 Biltmore Avenue and 428 Biltmore Avenue in Asheville, North Carolina, constitute an acute-care hospital, and the Employer has not presented extraordinary circumstances which warrant departure from the conclusion in the Board's Health Care Rule, Section 103.30(a) of its Rules and Regulations, that a unit of Registered Nurses, or RNs, is an appropriate unit. In what follows, I identify the primary factors and evidence on which the Employer relies to argue that the smallest appropriate unit is its proposed single-employer, multi-facility unit. I also explain my finding that the buildings at 428 and 509 Biltmore Avenue constitute a single acute-care hospital and my conclusion that the Employer has not rebutted the regulatory presumption that a unit of registered nurses at the Employer's acute-care hospital is an appropriate unit. Having concluded that the petitioned-for unit is appropriate, I direct an election in this matter.

II. FACTS

A. Operational Overview

HCA Healthcare purchased Mission Hospital and other entities in February 2019.[3] Mission

issued its decision in *Morrison Healthcare*, 369 NLRB No. 76 (2020), holding that representation hearings involving witness testimony should not be conducted telephonically, absent consent of the parties. 369 NLRB No. 76, slip op. at 1. The hearing in this matter included testimony from a number of witnesses. On June 3, 2020, the Acting Regional Director issued an Order to Show cause why the decision in this matter should not be based on the record made in the telephonic hearing and briefs already compiled and submitted. The Employer and the Petitioner responded that the decision should be made on the record already compiled and that the hearing should not be re-conducted or reopened. In view of the compelling circumstances, and the positions of the parties, the Acting Regional Director is basing her decision on the record developed during the telephonic hearing. See *Morrison Healthcare*, 369 NLRB No. 76, slip op. at 1 fn.4.

[2] The specific dates of the hearing were April 14, 25, 16, 17, 20, 21, 27, 29, and 30 and May 1, 4, and 6, 2020.

[3] HCA Healthcare owns other Mission Health-branded facilities in North Carolina, including acute-care hospitals Blue Ridge Medical Center, Transylvania Hospital, McDowell Hospital, Highland Cashiers Medical Center, and Angel Medical Center; various medical practices, such as HOPE Women's Cancer Center, Mission Cancer Center, MMA Mission Urology, MMA Neurology, MMA Olson Huff Center

Hospital is a private acute-care hospital, one of at least six in North Carolina operated by HCA Healthcare. Originally two separate institutions, St. Joseph's Hospital and Memorial Mission Hospital merged in the 1990s to become Mission St. Joseph's and later Mission Hospital.

The original Memorial Mission and St. Joseph's buildings are at 509 and 428 Biltmore Avenue, respectively, and are located across the street from one another less than a block apart. Four other Mission Health buildings are in the immediate vicinity at 520 and 534 Biltmore Avenue and 1 and 21 Hospital Drive. The building at 520 Biltmore houses administrative offices, including the one from which the Employer distributes employee ID badges and keys to employees. No party contends any nurses work there. 534 Biltmore is the home of Mission Imaging and Breast Center. Testimony about this site was limited to COO Joseph Rudisill noting it contains mammograph, ultrasound, bone density, and x-ray services. Employer Exhibit 5 identifies a separate corporate entity, MH Mission Imaging, LLLP, that presumably corresponds to this facility. While Employer counsel asserts a nurse employed by MH Hospital Manager, LLC, works at the site, the Employer's own list of MH Hospital Manager employees does not reflect or support this assertion. Additionally, the services at the imaging center are offered on an outpatient basis. 509 Biltmore includes its own radiology services and nurses assigned to that department.

Mission Health's facility at 21 Hospital Drive houses the State Employees Credit Union Cancer Center. That facility includes an adult infusion clinic, a pediatric hematology oncology infusion center, radiation therapy services, integrative health, and two physician practice groups, Mission Medical Oncology and Pediatric Hematology Oncology. The radiation therapy unit is "hospital-based."[4] There is an oncology unit within the main hospital building at 509 Biltmore.

Practice, MMA OP Neuro Practice, Carolina Vascular, and CarePartners, which itself comprises at least hospice care, long-term acute care, inpatient rehabilitation, and home health care.

[4] COO Rudisill described "hospital-based" as "anesthesia, radiology, pathology, hospitalists, ER physicians, and all the providers … defined as physicians, PAs, physician assistants, and nurse

Unlike the hospital oncology center, the services at Cancer Center are outpatient, and the Center is only open on weekdays.

One Hospital Drive houses a wound care clinic, weight management clinic, outpatient behavioral health clinic, offices, and case and care management personnel. The case and care management personnel there interact with patients at 509 Biltmore. As COO Joseph Rudisill put it,

> The majority of these folks start their day at Mission Hospital. Their number one priority is to help with the care and coordination and the continued care of the patients within this hospital. They do not have a desk job. Their job is to work on our nursing unit in order to help patients get to their next level of care, or to be discharged from the hospital.

Similarly, inpatient wound care nurses work out of the fourth floor of 428 Biltmore and see patients at 509 Biltmore, not 1 Hospital Drive. Thus, the registered nurses in inpatient wound care/care management, although identified as connected with 1 Hospital Drive, work in and serve the acute-care hospital's operations at 509 and 428 Biltmore.

The Memorial Mission and St. Joseph's buildings that compose Mission Hospital share an emergency department and operate under the same state license as an acute-care facility containing 733 general acute-care beds at 509 Biltmore and 82 psychiatric and behavioral care beds at 428 Biltmore. 428 Biltmore also houses Asheville Specialty Hospital, a separately licensed long-term care hospital, "a skilled nursing facility that has beds but not acute care beds."

Under the Mission Health umbrella, HCA Healthcare also operates various other facilities in North Carolina, which together compose the North Carolina Division. Nearly two dozen of those are within a ten-mile radius of Mission Hospital and are included in the Employer's proposed unit.

practitioners." Nurse Manager Melanie Clark, in contrast, said that term means workers are employed by or have a service agreement with the hospital, while Employer counsel characterized hospital-based groups as part of physician service group practices.

The corporate identity of the Employer in this case is MH Hospital Manager, LLC, a Delaware limited liability company wholly owned by MH Hospital Manager Holdings, Inc. MH Hospital Manager also owns the entirety of MH Asheville Specialty Hospital, LLC, the second corporate entity the Employer contends should be wrapped into the bargaining unit. The third corporate entity whose nurses the Employer contends should be included in the unit, Mission Health Community Multispecialty Providers, LLC (MH Multispecialty), is wholly owned by CarePartners Rehabilitation Hospital, LLLP, which, in turn, is 99 percent owned by MH Master Holdings, LLLP, which is itself 99 percent owned by MH Hospital Manager.

The corporate ownership units do not correspond to the organizational divisions the Employer witnesses identified. Thus, while Mission Hospital COO Rudisill identified CarePartners and Physician Service Groups as two branches of the North Carolina division or Mission Health portions of HCA Healthcare, no corporate entity plainly encompasses all and only either group.

The three identified employing entities – MH Hospital Manager, MH Asheville Specialty Hospital, and MH Multispecialty – also do not appear to correspond with the organizational structure of Mission Health. Thus, MH Hospital Manager employees work for CarePartners entities, physician service group practices, and Mission Hospital, as do MH Multispecialty workers. On the other hand, the nurses working for MH Multispecialty at 428 and 509 Biltmore are nurse practitioners, certified registered nurse anesthetists, and other advanced practice nurses[5] rather than regular RNs, and the MH Hospital Manager nurses work at the long-term care hospital.

The record does not clearly reflect the managerial structure or officers of MH Hospital

[5] Advanced practice nurse is a general term that applies to nurse practitioners, Certified Registered Nurse Anesthetists, midwives, and clinical nurse specialists, all of whom must be a registered nurse and carry certifications for their specialties.

Manager, MH Asheville Specialty Hospital, or MH Multispecialty. The Chief Executive Officer (CEO) of Asheville Specialty Hospital is Julie Dikos; the CEO for Mission Hospital is Chad Patrick; and the CEO for CarePartners is Tracy Buchanan. Buchanan also serves as a Board member for Asheville Specialty Hospital. However, it is unclear whether the officers of Asheville Specialty Hospital are also officers of MH Asheville Specialty Hospital; officers of Mission Hospital are officers of MH Hospital Manager; or officers of CarePartners are officers of MH Multispecialty.

B. Labor Relations at Mission Health

Labor relations at Mission Health are, at least at a high level, substantially centralized and uniform across organizational structure and corporate employers.

There is a single recruitment team for much or all of Mission Health, including its other acute-care hospitals.[6] The recruitment team maintains a "pipeline" of candidates for potential hire as needs arise and also works to fill open positions, which it learns of through a centralized applicant tracking system called iCIMS. The team posts for positions – applicants from both outside and within Mission Health see the same postings on the Mission Health website – and conducts initial screening interviews before attempting to arrange subsequent interviews with departmental hiring managers for qualified candidates. Recruiters make offers to candidates who managers want to hire and set initial compensation offers, based on existing guidelines, for those individuals. If a candidate accepts, the recruitment team initiates a background check of that person. Background checks and work authorization reviews are conducted for all new hires through a single vendor, PreCheck.

"Onboarding" of new hires is substantially the same for all new hires into Mission Health

[6] See above at fn. 3.

positions. The People Operations department sends a new hire an email with a link to an automated script that leads the new employee through various tasks, such as setting up direct deposit and completing withholding and deduction forms like W-4s; acknowledging receipt of Mission Health employment, immunization, and confidentiality policies; getting an employee badge; and establishing a Human Resources record. The employment policies manual given to new hires is the same for all workers. All new employees receive a health assessment at WorkWell to confirm they are ready for work. All new employees attend the same first half-day of orientation, after which participants split into clinical and non-clinical training groups. All newly hired nurses, regardless of facility, receive the same additional second day of training. However, other employees also receive additional role-specific training or orientation upon hire or transfer.

According to Wound Care Nurse Manager Shawn Beane, wound care nurses receive annual training comprising the same "clinical bundle" assigned to Mission Hospital nurses. Similarly, CarePartners Home Health and Hospice Marketing Director Kyla Boyles testified that "[her] nurses" are assigned training modules on an annual basis by the Human Resources department for new hires and by a specific clinical educator for training connected to inpatient rehabilitation. Psychiatric Evaluation RN Kate McGee testified that in her department, RNs, behavioral health techs, psychiatrists, and social workers all take the same CPR and life-support training and non-violent crisis intervention training.

The compensation and benefits available to new hires (and employees generally) are the same across facilities and organizational divisions. Human Resources Vice President Susan Stevens testified that all nurses in the Mission Health System receive periodic wage increases set at a fixed percentage. Discrimination and retaliation, substance use, attendance, and disciplinary policies are the same across positions, as well. Almost all employment-related policies apply uniformly across facilities.

Chief Nursing Officer Karen Olsen reviews final warnings and discharges for Mission Hospital nurses. Mission Hospital has its own Human Resources Vice President, Nyema Sayed, with a team of Human Resources managers and business partners assigned to her for that institution. Executive Director for Ambulatory Nursing Barbara Noon reviews all final warnings or discharges for nurses at a Physician Service Group. For all other employees, an area leader and North Carolina Division Human Resources Vice President Sheila Meadows review all proposed employee discharges, and a Human Resources "Business Partner" must review all proposed final warnings.

All Mission Health employees have an electronic personnel file, which is maintained on a system called Lawson. Corrective and disciplinary actions and attendance points are recorded in that file and available to managers across the Mission Health organization. Tenure and earned benefits, such as paid time off, do not change if an employee transfers from one Mission Health position to another as a successful internal job applicant.

A single payroll system exists for all Mission Health employees, and all hours an employee works at any facility in the Mission Health system are combined for purposes of pay, overtime, and benefit levels.

C. Supervision

Nursing unit supervisors are the immediate supervisors for all Mission Hospital RNs. Nursing unit supervisors report to nurse managers, who in turn report to a department manager, such as those for the children's department, perioperative services, or behavioral health services. Chief Nursing Officer (CNO) Karen Olson is the final authority over nurses at Mission Hospital. Nurses at the so-called hospital outpatient departments, which are generally free-standing facilities separate from the Mission Hospital buildings, are supervised by a clinical supervisor or director, who in turn reports to a department director, then to an assistant chief nursing officer, and finally

to CNO Olsen.

RNs at physician service group practices report up a chain to Director of Ambulatory Nursing Barbara Noon. RNs at the CarePartners Rehabilitation Hospital facility work under a reporting structure culminating in Executive Director Mitzi Holmes, while those at the hospice and palliative care facility are overseen by Hospice Director Michelle Warner and Executive Director Cathleen Adams.

Certified Registered Nurse Anesthetists, or CRNAs, are supervised by other CRNAs and anesthesiologists. Similarly, nurse practitioners are supervised separately from registered nurses. CRNAs, nurse practitioners, and advanced practice nurses at Mission Hospital are employed by MH Multispecialty, but RNs at Mission Hospital are employed by MH Manager.

The record contains limited evidence regarding which supervisors make job assignments, schedule staff, discipline or reward, and conduct performance evaluations of nurses, but team leaders and charge nurses make patient assignments to at least some RNs.

Local supervisors at specific facilities prepare scheduling for nurses. For instance, the CarePartners Rehabilitation Hospital has a staffing supervisor responsible for scheduling the proper number of nurses and obtaining additional personnel when needed to meet demand. The job description of Nursing Unit Manager lists "oversight for staffing and scheduling" as a performance criterion. Department managers appear to hire and fire.

At least one nurse manager in wound healing completes performance evaluations for the nurses who report to him. Moreover, job descriptions included in Employer Exhibit 20 indicate departmental managers are responsible for discipline and evaluation of nurses below them. The role description of Nursing Unit Manager says the position is "[r]esponsible and accountable for [the] daily operations of a designated clinical area," "[e]valuates performance of staff in a fair and transparent manner," and "facilitates appropriate orientation for new staff and provides feedback

on staff development and progress." Similarly, the job description for RN Clinical Manager-Physician Practice states that person:

> 1. [A]cts as the clinical leader and staff supervisor who oversees the performance, daily operations, programs, and activities of assigned clinical staff under the direction of the Regional Director of Ambulatory Nursing,
> 2. Hires and retains qualified and diverse staff … [d]ocuments concerns, discusses counseling option, and provides corrective action when needed for assigned staff members, and
> 3. Provides clinical staff with a 90-day review and engages team members in weekly check-ins and quarterly talent conversations.

D. Employee Interchange

Various Employer witnesses testified that nurses "float" from and to various facilities, have transferred from facility to facility, or have a "dual role" at more than one facility. For instance, Mission Children's Specialist Amber Hyman testified she has asked for and been assigned nurses from Mission Hospital when she has been short-staffed. Similarly, Asheville Surgery Center Director Kristi Hensley testified that nurses from other facilities work at the Surgery Center and nurses from the Surgery Center go to the hospital and 1 Hospital Drive. Asheville Surgery Hospital CEO Julie Dikos testified that three nurses "go back and forth" from Asheville Surgery Hospital and Mission Hospital "frequently." CarePartners Home Health Director of Operations Joette Santora described transfers between home health care and Mission Hospital units, and CarePartners Hospice and Palliative Care Clinical Manager Fran Kyles described both hospice nurses picking up shifts at other facilities – not always in nursing jobs – and hospital nurses coming to the hospice to assist patients.

There is also an "internal staffing pool" of CarePartners nurses. That group includes about 20 nurses who can be assigned to certain unspecified physician service group practices, post-acute CarePartners facilities, the WorkWell facility, and Mission Hospital, but not hospital outpatient departments.

The record also included documentary evidence regarding the extent to which two individual employees, one of whom was a nurse, had worked at facilities other than their "home" worksites. Despite the centralized and computerized nature of its payroll records, the Employer did not submit evidence establishing the extent of employee interchange, relying instead on general testimony concerning facilities at which various employees had worked.

Petitioner called a few nurses who testified to limited interchange. Bevin McGahey has been a registered nurse at Asheville Surgery Center for three years. Until transferring to that center, he worked for 15 years at Mission Hospital. He testified that during his time at Mission Hospital, he did not witness nurses "float" from there to Asheville Surgery Center and, since moving to Asheville Surgery Center, he has observed RNs working there float to Mission Hospital only a few times. Similarly, neonatal ICU nurse Alison Gold testified she has not witnessed outpatient nurses floating into her unit, and she does not float to outpatient facilities. Likewise, RN Andrew Hoaglan testified that over the five and a half years he has worked in the Mission Hospital operating room, he has seen nurses from Asheville Surgery Center working in the Mission Hospital operating room only a handful of times, though it has happened more frequently since the COVID-19 pandemic began.

Finally, RNs do not interchange with nurse practitioners, CRNAs, or other advanced practice nurses. Both CRNAs and nurse practitioners can make diagnoses and prescribe medications. RNs cannot do either. The work of CRNAs and nurse practitioners is outside the scope of RNs.

E. Functional Integration

The record evidence establishes broad functional integration among many of the Mission Health facilities and operations. In addition to the centralized human resources and labor relations programs described above, various facilities share top-level supervision. Executive Director

Barbara Noon, for example, oversees all non-inpatient nurses, and there is a Chief Certified Registered Nurse Anesthetist with responsibilities across five affiliated hospitals. Pharmacy operations are centralized to a significant respect, as are laundry and education and training of clinical staff. Electronic medical records are maintained across all facilities on a single platform called Cerner.

Mission Hospital refers patients to at least two other Mission Health facilities, Asheville Specialty Hospital, which is the long-term care hospital at 428 Biltmore, and CarePartners Rehabilitation Hospital. Marketing Director Sid Heilbraun oversees a team of liaisons who conduct daily reviews of reports designed to identify patients who would be good candidates for such referrals.

Additionally, Mission Health maintains several committees that integrate participants from across facilities and organizational structure, such as the Falls Committee, which reviews patient falls and the means for preventing them across Mission Health; Informatic Committee, which reviews and makes recommendations regarding the charting system for all Mission Health facilities; Quality Committee; and CLABSI committee, which investigates central line infections and makes organization-wide recommendations and practice revisions.

F. Education, Certification, Skills, and Working Conditions

While nurse practitioners must hold a master's degree in nursing, an RN may have an associate's or bachelor's degree. Nurse practitioners may diagnose patient illnesses while RNs may not.

Nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, and other advanced practice nurses must hold a Master of Sciences degree in Nursing. While a registered nurse must be licensed by the state board of nursing, midwives, CRNAs, nurse specialists, nurse practitioners, and other advanced practice nurses must have

separate certifications.

Nurse practitioners are salaried, rather than hourly, employees like RNs and thus do not earn holiday pay, overtime, or sick leave in the way RNs do. CRNAs are also salaried and make substantially more than at least surgery RNs.

Finally, nurse practitioners are not required to wear a uniform, while RNs are required to wear navy or white scrub pants and a white scrub top.

III. ANALYSIS

The determinative factor in this case, notwithstanding the plethora of additional facts the Employer provided, is the status of Mission Hospital at 428 and 509 Biltmore Avenue as a single acute-care hospital under the National Labor Relations Board's Health Care Rule, and the Board's determination that a unit of registered nurses at an acute-care hospital is an appropriate unit.

The Board's Health Care Rule at Section 103.30(a) of the Board's Rules and Regulations, labeled "Appropriate bargaining units in the health care industry," reads, in relevant part:

> (a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of this section: Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that, if sought by labor organizations, various combinations of units may also be appropriate:
> (1) All registered nurses.

Petitioner, a labor organization, filed its representation petition in this matter under Section 9(c)(1)(A)(i) of the Act and seeks an election in a unit of the Employer's registered nurses. The only remaining questions are (1) whether the Employer's hospital at 428 and 509 Biltmore Avenue is a single hospital; (2) whether that single hospital is an acute-care hospital; and (3) whether the Employer has established "extraordinary circumstances" that would warrant finding that a unit of

the Employer's registered nurses is not an appropriate unit or the only appropriate unit.[7]

The facts establish that 509 and 428 Biltmore compose a single hospital known as Mission Hospital. COO Joseph Rudisill characterized those two buildings as one acute-care hospital, stating, "Mission Hospital is – it encompasses two campuses. It – the history of Mission Hospital is the adjoining of two hospitals, St. Joseph's and Memorial Mission … [which] eventually evolved into Mission Hospital." Rudisill also noted that the two buildings share an emergency department: "[T]here's only one emergency department between 509 and 428." In addition, the North Carolina Department of Health and Human Services considers Mission Hospital to be a licensed hospital with beds at 509 and 428 Biltmore.

Employer's counsel sometimes characterizes Mission Hospital as limited to the building at 509 Biltmore, sometimes contends that the acute-care hospital "includes various out-patient clinics and centers," and sometimes argues that the acute-care hospital covered by the Health Care Rule necessarily encompasses at least the other buildings identified on Employer Exhibit 7, an Employer-produced map labeled "Mission Hospital." On the other hand, Employer counsel also contends that 509 and 428 Biltmore constitute more than one facility. The Employer argues the single-facility presumption cannot apply because the petition identifies two buildings, namely 509 and 428 Biltmore.

As to this last point, the Board has repeatedly found that multiple buildings may constitute a single facility. See, e.g., *California Pacific Medical Center*, 357 NLRB 197, 197–198 (2011) (applying single-facility presumption to St. Luke's campus and holding that employer did not rebut presumption; the campus there, as identified in the regional director's decision, consisted of "about

[7] In light of my other findings, I also conclude below that advanced practice nurses employed by MH Multispecialty and registered nurses employed by MH Asheville Specialty Hospital, LLC, and working at the long-term care facility, Asheville Specialty Hospital, do not belong in the bargaining unit.

five buildings," *California Pacific Medical Center*, 20–RC–18207, p. 7, fn.10 (Mar. 31, 2011)); *North Hills Office Services*, 342 NLRB 437, 437 fn.3 (2004) (applying single-facility presumption to office cleaning work at a pair of buildings at 201 and 301 Route 17 North, Rutherford, New Jersey, comprising "the Meadows Complex"); *First Security Services Corp.*, 329 NLRB 235, 235 & fn.1 (1999) (applying single facility presumption to locations five miles apart that "compris[ed] the Bridgeport Hospital jobsite").

Further, in the process of adopting the Health Care Rule, the Board specifically rejected the idea that "single institutions occupying more than one contiguous building" were sufficiently different to warrant different treatment from other hospitals. Collective-Bargaining Units in the Health Care Industry (Second Notice of Proposed Rulemaking), 53 Fed. Reg. 33900, *3392, 1988 WL 253950 (1988). In light of the preceding, I cannot agree with the Employer that, "The Board has generally defined a single facility as being coextensive with a single building." *St. Vincent Healthcare*, 27–RC–8577, p. 23 (Dec. 4, 2009) (regional director's decision and direction of election).[8]

Accordingly, I find that the two buildings at 509 and 428 Biltmore are Mission Hospital, a single integrated hospital.

The evidence also establishes that Mission Hospital is an acute-care hospital. The Employer repeatedly admitted, and the facts clearly establish, that Mission Hospital at 428 and 509 Biltmore Avenue jointly constitute a single acute-care hospital. HCA Healthcare Management

[8] The Employer misreads the Board's statement in *Manor Healthcare Corp.*, 285 NLRB 224, 225 (1987), "The Board has long held, of course, that a single-facility unit geographically separated from other facilities operated by the same employer is presumptively appropriate for the purpose of collective bargaining even though a broader unit might also be appropriate." Id. at 225. While that may have been applicable here if the Employer were operating Memorial Mission and St. Joseph's hospitals as two, separate hospitals, that is not the case. The unit here is a single hospital – Mission Hospital – that happens to be housed in two, separate buildings across the street from one another. That distinction is borne out in the cases cited above and in the administrative history of the Health Care Rule.

Services Vice President in tax research Glen Mortensen, who was involved in HCA Healthcare's acquisition of Mission Hospital and associated entities, characterized Mission Hospital as an acute-care hospital. Asheville Specialty Hospital CEO Julie Dikos also described Mission Hospital as an acute-care hospital, stating, "[T]he hospital at 509 Biltmore is a short-term acute-care hospital," and Employer counsel in his post-hearing brief characterized 509 Biltmore as "the actual acute hospital." The buildings at 428 and 509 Biltmore also fit the definition of acute-care hospital in subsection (f)(2) of the Health Care Rule, Section 103.30(f)(2) of the Board's Rules and Regulations:

> *Acute care hospital* is defined as: either a short term care hospital in which the average length of patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days. Average length of stay shall be determined by reference to the most recent twelve month period preceding receipt of a representation petition for which data is readily available. The term "acute care hospital" shall include those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, psychiatric care, or rehabilitative care, but shall exclude facilities that are primarily nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals.

Because CEO Julie Dikos described Asheville Specialty Hospital as a "long-term acute care hospital" where the "average length of stay is 25 days" and contrasted that institution with "the hospital at 509 Biltmore …[,] a short-term acute care hospital," one can readily infer that the average length of stay at Mission Hospital is less than 25 days and necessarily, "less than thirty days" as required under Section 103.30(f)(2). Mission Hospital COO Rudisill also made this distinction between Asheville Specialty Hospital and Mission Hospital.

Based on the Employer's admissions and the facts, I find that Mission Hospital, at 509 and 428 Biltmore Avenue, is a single acute-care hospital. The further question is whether additional buildings in and around the hospital are also part of the acute-care hospital; specifically, whether the acute-care facility Mission Hospital extends beyond 509 and 428 Biltmore Avenue. See *Saint*

Mary's Regional Medical Center, 32–RC–156669, 2016 WL 3548045 (2016) (remanding to Regional Director to determine whether "satellite" location "is, or is part of, an acute care facility as defined in the Rule"; not reported in Board volumes). Given the facts described above, I conclude that the acute-care hospital is limited to the two buildings, 509 and 428 Biltmore Avenue, identified by COO Rudisill.

One of the other buildings in the immediate vicinity, 520 Biltmore, houses only administrative offices. The only activity attributed to this building in the record of this case is the distribution of ID badges and keys to new employees. Because the Employer offers no medical services, much less any acute-care services, at that building, I conclude it is not a part of the acute-care Mission Hospital.

While the Mission Imaging and Breast Center at 534 Biltmore offers medical services, its services are on an outpatient basis, and the Center does not appear to support the hospital, which has its own internal radiology department and radiology workers. While the Board's definition of an acute-care hospital includes "those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, … outpatient care," Rules and Regulations, Sec. 103.30(f)(2), that definition also implies that outpatient care by itself does not normally constitute a hospital service. Thus, I conclude that the imaging services at Mission Imaging and Breast Center are also not a constituent part of the acute-care services the Employer provides at Mission Hospital.

The same is true of the State Employees Credit Union Cancer Center at 21 Hospital Drive. Mission Hospital's 509 Biltmore building has its own oncology department and nurses and the services offered at the Cancer Center are provided on an outpatient rather than inpatient basis. Further, because the Center is open only on weekdays, it does not meet the Board's statutory definition of a hospital. Section 103.30(f)(1) of the Board's Rules and Regulations adopts the

definition of "hospital" in the Medicare Act, set forth at 42 U.S.C. § 1395x(e), which in turn restricts that term to institutions primarily engaged in providing inpatient medical services under the supervision of physicians and which, among other things, provide 24-hour nursing services. Because the Center is not primarily engaged in providing inpatient service and does not have 24-hour nursing services, it too is not a constituent component of Mission Hospital.

Finally, while 1 Hospital Drive is home to offices for some supervisors of the staff who work at 509 and 428 Biltmore, the inpatient acute-care services that Mission Hospital provides are performed at 509 and 428 Biltmore, not 1 Hospital Drive. While the Employer's counsel correctly notes the Board has said that business office clerical employees working for a given acute-care hospital frequently work "outside the health care facility," that does not imply that any building where work in support of a hospital is performed is thereby part of the hospital. Indeed, the Board's language indicates otherwise, since it distinguishes between the health care facility on the one hand and the administrative offices outside it. In the present case, the threshold question is not whether a specific group of employees is properly part of a bargaining unit – the inpatient care managers and inpatient wound care nurses both work at 509 Biltmore, with the latter group also working out of 428 Biltmore – but whether a separate building housing offices of supervisors for those employees thereby becomes a part of the relevant "health care facility." In attempting to delineate the scope of the acute-care hospital, I rely on the Board's adopted definition of "hospital," which looks first to the services the institution "is primarily engaged in providing." Here, the Employer provides critical hospital services at 509 and 428 Biltmore, not 1 Hospital Drive. I therefore conclude that the scope of the acute-care hospital is properly limited to Mission Hospital at 509 and 428 Biltmore Avenue.

Because I have concluded that the operations at 509 and 428 together compose a single acute-care hospital, the petitioned-for unit of registered nurses working for Mission Hospital at

those buildings is appropriate under the Board's Health Care Rule unless the Employer has shown extraordinary circumstances warranting a different unit determination.

In its final version of the Health Care Rule, the Board "reaffirm[ed] the scope of the extraordinary circumstances exception as set forth in in [the Second Notice of Proposed Rulemaking]." Collective-Bargaining Units in the Health Care Industry (Final Rule), 54 Fed. Reg. 16336, *16345, 1989 WL 299510 (1989). In the earlier notice, the Board wrote, "To satisfy the requirement of extraordinary circumstances, a party would … bear the heavy burden to demonstrate that its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding." 53 Fed. Reg. 33900, *33933, 1988 WL 253950 (internal quotation marks omitted). The Board also listed some of the matters it had considered which do *not* constitute extraordinary circumstances, singly or jointly:

> (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nationwide hospital "chains'; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) ***single institutions occupying more than one contiguous building.***

53 Fed. Reg. 33900, *339323, 1988 WL 253950 (Emphasis added.)[9]

In its Statement of Position, the Employer lists various reasons for finding the petitioned-for unit inappropriate: (i) it includes or potentially includes managers, technical employees,

[9] Accordingly, the fact that Mission Hospital constitutes two separate buildings would fare no better when posited as an argument that extraordinary circumstances warrants deviating from the administratively determined appropriate unit of registered nurses employed at the acute-care hospital.

business office clericals, skilled maintenance employees, and other non-professional employees; (ii) it excludes or fails to include registered nurses the Employer contends share a sufficient community of interest with those in the petitioned-for unit; (iii) it excludes or fails to include registered nurses working elsewhere "in the Employer's integrated enterprise … consisting of MH Hospital Manager, LLC, Mission Health Community Multispecialty Providers, LLC, and MH Asheville Specialty Hospital, LLC"; (iv) it would result in the proliferation of bargaining units; and (v) it is based on the extent of organization."

Because it is the Employer's burden to establish the managerial status of specific employees in order to properly exclude them from the bargaining unit, *Republican Co.*, 361 NLRB 91, 96 (2014), and because Petitioner's unit description explicitly excludes "all other employees" and "other professional employees" from the unit sought of "[a]ll full-time, regular part-time, and per diem Registered Nurses," thereby barring inclusion of technical employees, business office clericals, skilled maintenance employees, and other non-professional employees, the Employer's first extraordinary circumstance fails. Because the Employer did not present any evidence that the petition was based on the extent of organization, its fifth reason also fails. Because the Board has already considered and rejected the conclusion that a unit of RNs at an acute-care hospital would result in undue proliferation of bargaining units, the Employer's fourth reason fails. See 53 Fed. Reg. 33900, *33933, 1988 WL 253950 ("A thorough examination of the record in this rule-making proceeding has satisfied us that the health care units established by the Board do not constitute proliferation either in terms of the legislative history of the amendments or in the context of the history or realities of the industry").

The remaining two purported extraordinary circumstances reduce to the argument that the petitioned-for unit is inappropriate because it excludes registered nurses working at other facilities. The Employer contends that nurses at its non-acute facilities are subject to similar working

conditions as nurses at Mission Hospital in light of high-level common supervision and labor relations, and the Mission Health non-acute facilities and Mission Hospital form an integrated whole. However, at the time it adopted the Health Care Rule, the Board was aware of variation in the provision of health care services, including "establishing new types of related health care services on outpatient as well as inpatient bases," "expanding … markets by developing … specialty units," and hospitals "becoming parts of larger systems encompassing intermediate care facilities, urgent care centers, nursing homes, surgery centers, clinics, etc." The Board was also aware of claims of extensive functional integration of work, as noted above. The Board nonetheless found a unit of registered nurses at an acute-care hospital to be appropriate.

In short, because the Employer does not raise any arguments substantially different from those considered at the time the Board adopted the Health Care Rule, it has failed to "bear the 'heavy burden' to demonstrate that its arguments are substantially different from those which have been carefully considered in the rulemaking proceedings." *St. Margaret Memorial Hospital*, 303 NLRB 923, 923 (1991). The Employer has therefore not demonstrated extraordinary circumstances that would justify departure from the Health Care Rule.

In view of my conclusion that the unit is appropriate under the Health Care Rule and that the Employer has not demonstrated extraordinary circumstances, the Employer's other arguments about the appropriate unit are beside the point. In any event, its contention that the only appropriate unit sweeps in all the facilities and corporate entities encompassed in "the Employer's integrated enterprise … consisting of MH Hospital Manager, LLC, Mission Health Community Multispecialty Providers, LLC, and MH Asheville Specialty Hospital, LLC" has no basis in law. In *Visiting Nurses Assn. of Central Illinois*, 324 NLRB 55 (1997), for example, the Board assumed a visiting nurse service and an acute-care hospital were a single employer but treated the nurse service as its own single facility even where the two facilities were in "close proximity," RNs

worked at both, the acute-care hospital managed high-level labor relations for the nurse service, the two shared non-medical services, and RNs "floated" from the hospital to the other facility. 324 NLRB at 55–56. The Board emphasized that "[the nursing association's] services – home health and hospice care – are distinct from those provided by [the hospital]" and attached significant weight to the separate day-to-day labor relations control of the nursing association. Id. at 55. As in that case, local Mission Hospital managers interview and make hiring decisions on job applicants as well as evaluate and discipline employees.

Finally, I consider the Employer's argument that nurse practitioners, CRNAs, and other advanced practice nurses working at Mission Hospital but employed by MH Multispecialty, and RNs employed by MH Asheville Specialty Hospital, LLC and working at the long-term care facility Asheville Specialty Hospital, must also be included in the unit. I find the Employer's arguments unpersuasive. The registered nurses and the advanced practice nurses and those employed in the MH Asheville Specialty Hospital within Mission Hospital do not share a community of interests with the registered nurses employed by Mission Hospital in the hospital. Whether they have a community of interests turns on bargaining history, if any; the extent of the functional integration of operations; the differences in the types of work and the skills of employees; the extent of centralization of management and supervision, particularly as to labor relations and control of day-to-day operations; and the extent of interchange and contact between the groups of employees. See, e.g., *Edenwald Construction Co.*, 294 NLRB 297, 297 (1989).

There is no bargaining history at the three entities employing the different groups of nurses; the functional integration is, as set forth above, substantial; there is no significant centralization of supervision in terms of day-to-day operations, in hiring, work assignments, discipline, or employee evaluation, but there is extensive centralization in terms of employment policies, compensation, and benefits; and while there is little evidence of interchange generally, it is clear

RNs do not fill in for CRNAs, nurse practitioners, or other advanced practice nurses. The supervisory structure, skills, types of work, and working conditions are different for RNs than for CRNAs, nurse practitioners, and other advanced practice nurses.

In similar circumstances, the Board has found combination of the two employer's production employees inappropriate. *Lawson Mardon USA*, 332 NLRB 1282 (2000). That case involved two employers that composed a single employer under Board law whose employees worked in a single structure, though one group was separated from the other by air-locked doors. The Board relied heavily on the facts that the two groups of employees had "separate immediate and intermediate daily supervision," there was "almost no temporary interchange," and "current instances of permanent interchange [we]re not substantial." Id. at 1282. The Board discounted the common human resources department, id. at fn.3, despite the Regional Director's findings that all employees were subject to the same rules and disciplinary policies, received the same employee handbook, attended monthly safety meetings, could use any breakrooms in the facility, could apply for positions in either employer using the same bid form, learned of vacancies for either employer from the same bulletin boards, and had very similar benefits, including service and attendance awards, paid vacation, ten paid holidays, profit sharing, a 401(k) plan, and more. Id. at 1284.

I therefore find that the nurse practitioners, CRNAs, and other advanced practice nurses employed by MH Multispecialty are not appropriately included in the unit of RNs employed at Mission Hospital by MH Hospital Manager, LLC. As in *Lawson Mardon*, the two groups of employees here have different supervision responsible for day-to-day labor relations, there is no evidence of interchange between the two groups, and the two groups wear different uniforms. While the record in *Lawson Mardon* included greater physical separation of the two working groups than is present here, the skills and compensation of the two groups were much more similar than here as well. 322 NLRB at 1826.

Lawson Mardon is also instructive regarding the RNs employed by MH Asheville Specialty Hospital, LLC. As in that case, the two groups of employees work in separate parts of the same building and are engaged in different aspects of the combined entity's business. In *Lawson Mardon*, one group of employees produced food-packaging products while the other produced pharmaceutical packaging; here, one group of RNs works in the short-term acute-care hospital while the other works in the long-term skilled nursing facility. In light of that fact, the distinct supervisory structures for the two sets of nurses, and the fact the Asheville Specialty Hospital is distinct from the Mission Hospital acute care facility (and therefore not encompassed by the unit authorized under the Health Care Rule), I also find that the RNs at MH Asheville Specialty Hospital should not be included in the unit.

IV. CONCLUSION

Based upon the entire record in this matter and in accordance with the discussion above, I conclude and find as follows:

1. The rulings at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. Petitioner is a labor organization within the meaning of Section 2(5) of the Act and claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. The following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

Included: All full-time, regular part-time, and per diem Registered Nurses employed

by MH Hospital Manager, LLC, at its acute-care hospital, Mission Hospital, at 509 Biltmore Avenue and 428 Biltmore Avenue, Asheville, North Carolina.

Excluded: All other employees; Nurse Practitioners, CRNAs, and other advanced practice nurses employed by MH Multispecialty; Registered Nurses employed by MH Asheville Specialty Hospital, LLC; guards, and supervisors as defined in the National Labor Relations Act.

The parties agree a per diem registered nurse shall be eligible to vote if she or he averaged four or more hours per week of work in the 13 weeks preceding the eligibility date. *Davison-Paxon Co.*, 185 NLRB 21 (1970).

V. DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the unit found appropriate above. Employees will vote whether they wish to be represented for purposes of collective bargaining by National Nurses Organizing Committee–North Carolina/National Nurses United.

A. Election Details

Both parties were given an opportunity to argue their positions as to the election method and did so during the hearing and in their post-hearing briefs. The Employer argued that the Board's preferred method of election is manual, that "there is no basis to believe a manual election poses any danger to employees or Board agents," that the Employer has "instituted procedures to protect everyone entering its facilities," and that Petitioner has not shown a manual election could not be held safely. For the employees at 428 and 509 Biltmore Avenue, the Employer proposes holding three polling sessions per day spanning 13-1/2 hours each day for three days at four separate sites to accommodate the roughly 1600 employees working at those buildings.

Petitioner argues the Board has authorized mail-ballot elections during extraordinary circumstances and contends that the COVID-19 pandemic constitutes extraordinary circumstances justifying a mail-ballot election, the mitigation and protection efforts undertaken by the Employer cannot be relied upon to protect voters and Board personnel, and the number of COVID-19 cases

has not decreased enough to conclude an in-person election can be conducted safely.

Having reviewed the record and the parties' positions, I conclude that holding a **mail ballot** election will be the best means of conducting the election in this matter.[10]

On March 10, 2020, North Carolina Governor Roy Cooper issued Executive Order 116, declaring a State of Emergency in response to the COVID-19 pandemic; two and a half weeks later Governor Cooper instituted a stay-at-home order by Executive Order 121, which prohibited most individuals from traveling other than for certain essential activities and limited gatherings of more than ten (10) people in a single room or space, including confined outdoor spaces.

On May 20, 2020, Governor Cooper lifted the stay-at-home order and relaxed the limitations on gatherings outdoors, based in part on an assessment that North Carolina had "'flattened the curve' and prevented a surge or spike in cases across the state." However, the North Carolina Department of Health has reported that COVID-19 cases and deaths in the State have continued to rise and on June 24, 2020, Governor Cooper extended Executive Order 141 both temporally and to require face coverings. That Executive Order, number 147, also requires skilled nursing facilities to "restrict visitation of all visitors and non-essential health care personnel." On July 16, 2020, Governor Cooper again extended so-called Phase 2 measures via Executive Order 151, which currently stands.

The North Carolina Department of Health reported 2344 laboratory-confirmed new COVID-19 cases on July 31, 2020, the third-highest day on record. To date, the State has reported more than 126,000 confirmed COVID-19 cases and has been characterized as a "red zone" state for new infections. Buncombe County, of which Asheville is the seat, has reported more than 1700 confirmed cases.

[10] I note that the hearing in this matter concluded prior to the issuance of Memorandum GC 20-10, Suggested Manual Election Protocols.

In *San Diego Gas and Electric,* 325 NLRB 1143 (1998), the Board reviewed the circumstances under which it may be appropriate to direct a mail ballot election. The Board's longstanding policy has been that, as a general rule, representation elections should be conducted manually. Recognizing, however, that there are some circumstances that would make it difficult for eligible employees to vote in a manual election, the Board has vested Regional Directors with broad discretion to determine the method by which elections shall be conducted.

Under non-pandemic circumstances, it is likely that I would direct such a manual election. However, under current circumstances, I have determined that an in-person manual election under poses significant and unnecessary risks to the health and safety of voters, observers, Board Agents, and party representatives, whose presence would be required at a manual election. The estimated number of eligible voters is 1600, which will necessitate long polling hours in multiple shifts to accommodate employees' schedules in a 24-hour facility, as well as multiple Board agents to oversee the election. Further, bringing together the diverse parties, Board agents, and others who would not otherwise be present at an acute-care health care facility – or gathered at all – increases the risks to other employees and patients at the facility. Under the Board's manual election procedures, Board Agents conducting the election and election observers are required to spend the duration of the polling session and ballot count process together in relatively close proximity within a confined space, which necessarily carries a risk of exposure. In a hospital setting, it is highly unlikely that the Employer would be able to certify that, on the day of the election, no individuals were present in the facility who had not tested positive for COVID-19 within the prior 14 days; were not awaiting results of a COVID-19 test; or had not had direct contact with anyone in the previous 14 days who has tested positive for COVID-19.

Conducting the election in this case by mail ballot, however, significantly reduces these risks. Conducting a mail ballot election will enable Board Agents, voters, observers, and party

representatives to maintain safe social distancing throughout the polling process, which will ensure that this election is conducted with minimal risk to the participants' personal safety and public health. Based on the above and the record as a whole, I find that the ongoing COVID-19 pandemic presents extraordinary circumstances that make a mail-ballot election the only appropriate election method in this case.

Accordingly, the election will be conducted by United States mail. The ballots will be mailed to employees employed in the appropriate collective-bargaining unit. On **Tuesday, August 18, 2020**, ballots will be mailed to voters by the National Labor Relations Board, Region 10. Voters must sign the outside of the envelope in which the ballot is returned. Any ballot received in an envelope that is not signed will be automatically void. Ballots will be returned to National Labor Relations Board, Region 10, Subregion 11, Republic Square, 4035 University Parkway, Suite 200, Winston-Salem, North Carolina 27106-3325.

Those employees who believe that they are eligible to vote and did not receive a ballot in the mail by Tuesday, September 1, 2020, should communicate immediately with the National Labor Relations Board by either calling the Region 10 Office at (404) 331-2896 or our national toll-free line at 1-844-762-NLRB (1-844 762-6572).

All ballots will be commingled and counted at the Subregion 11 Office at 2:00 P.M. on **Wednesday, September 16, 2020**. Based on COVID-19 pandemic developments, the ballot count may be conducted by way of videoconference. In order to be valid and counted, the returned ballots must be received in the Subregion 11 Office located at Republic Square, 4035 University Parkway, Suite 200, Winston-Salem, North Carolina 27106-3325, prior to counting of the ballots.

B. Voting Eligibility

The following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> **Included:** All full-time, regular part-time, and per diem Registered Nurses employed by MH Hospital Manager, LLC, at its acute-care hospital, Mission Hospital, at 509 Biltmore Avenue and 428 Biltmore Avenue, Asheville, North Carolina.
>
> **Excluded:** All other employees; Nurse Practitioners, CRNAs, and other advanced practice nurses employed by MH Multispecialty; Registered Nurses employed by MH Asheville Specialty Hospital, LLC; guards, and supervisors as defined in the National Labor Relations Act.

The parties agree a per diem registered nurse shall be eligible to vote if she or he averaged four or more hours per week of work in the 13 weeks preceding the eligibility date. *Davison-Paxon Co.*, 185 NLRB 21 (1970).

Those eligible to vote in the election are employees in the above unit who were employed during the payroll period ending August 1, 2020, including employees who did not work during that period because they were ill, on vacation, or were temporarily laid off.

Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced are also eligible to vote. In addition, employees engaged in an economic strike which commenced less than 12 months before the election date, who have retained their status as strikers but who have been permanently replaced, as well as their replacements are eligible to vote. Employees who are otherwise eligible but who are in the military services of the United States may vote if they appear in person at the polls or by mail as described above.

Ineligible to vote are (1) employees who have quit or been discharged for cause after the designated payroll period for eligibility, (2) employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or

reinstated before the election date, and (3) employees engaged in an economic strike which began more than 12 months before the election date who have been permanently replaced.

C. Voter List

As required by Section 102.67(l) of the Board's Rules and Regulations, the Employer must provide the Regional Director and parties named in this decision a list of the full names, work locations, shifts, job classifications, and contact information (including home addresses, available personal email addresses, and available home and personal cell telephone numbers) of all eligible voters.

To be timely filed and served, the list must be *received* by the regional director and the parties by **Thursday, August 6, 2020**. The list must be accompanied by a certificate of service showing service on all parties. **The Region will no longer serve the voter list.**

Unless the Employer certifies that it does not possess the capacity to produce the list in the required form, the list must be provided in a table in a Microsoft Word file (.doc or docx) or a file that is compatible with Microsoft Word (.doc or docx). The first column of the list must begin with each employee's last name and the list must be alphabetized (overall or by department) by last name. Because the list will be used during the election, the font size of the list must be the equivalent of Times New Roman 10 or larger. That font does not need to be used but the font must be that size or larger. A sample, optional form for the list is provided on the NLRB website at www.nlrb.gov/what-we-do/conduct-elections/representation-case-rules-effective-april-14-2015.

When feasible, the list shall be filed electronically with the Region and served electronically on the other parties named in this decision. The list may be electronically filed with the Region by using the E-filing system on the Agency's website at www.nlrb.gov. Once the website is accessed, click on **E-File Documents**, enter the NLRB Case Number, and follow the

detailed instructions.

Failure to comply with these requirements will be grounds for setting aside the election whenever proper and timely objections are filed. However, the Employer may not object to the failure to file or serve the list within the specified time or in the proper format if it is responsible for the failure.

No party shall use the voter list for purposes other than the representation proceeding, Board proceedings arising from it, and related matters.

D. Posting of Notices of Election

Pursuant to Section 102.67(k) of the Board's Rules, the Employer must post copies of the Notice of Election accompanying this Decision in conspicuous places, including all places where notices to employees in the unit found appropriate are customarily posted. The Notice must be posted so all pages of the Notice are simultaneously visible. In addition, if the Employer customarily communicates electronically with some or all of the employees in the unit found appropriate, the Employer must also distribute the Notice of Election electronically to those employees. The Employer must post copies of the Notice at least 3 full working days prior to 12:01 a.m. of the day of the start of the election, Thursday, August 13, 2020, and copies must remain posted until the end of the election, Wednesday, September 16, 2020. For purposes of posting, working day means an entire 24-hour period excluding Saturdays, Sundays, and holidays. However, a party shall be estopped from objecting to the nonposting of notices if it is responsible for the nonposting, and likewise shall be estopped from objecting to the nondistribution of notices if it is responsible for the nondistribution.

Failure to follow the posting requirements set forth above will be grounds for setting aside the election if proper and timely objections are filed.

VI. RIGHT TO REQUEST REVIEW

Pursuant to Section 102.67 of the Board's Rules and Regulations, a request for review may be filed with the Board at any time following the issuance of this Decision until 14 days after a final disposition of the proceeding by the Regional Director. Accordingly, a party is not precluded from filing a request for review of this decision after the election on the grounds that it did not file a request for review of this Decision prior to the election. The request for review must conform to the requirements of Section 102.67 of the Board's Rules and Regulations.

A request for review may be E-Filed through the Agency's website but may not be filed by facsimile. To E-File the request for review, go to www.nlrb.gov, select E-File Documents, enter the NLRB Case Number, and follow the detailed instructions. If not E-Filed, the request for review should be addressed to the Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570-0001. A party filing a request for review must serve a copy of the request on the other parties and file a copy with the Regional Director. A certificate of service must be filed with the Board together with the request for review.

Neither the filing of a request for review nor the Board's granting a request for review will stay the election in this matter unless specifically ordered by the Board.

Dated: August 4, 2020

Lisa Y. Henderson, Acting Regional Director
National Labor Relations Board
Region 10
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